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2002 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2002)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0038331		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER
	Number City Zi County: LaSalle Telephone Number: (815) 672-4516 Fax # ()	61701 Cip Code	I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information
	Date of Initial License for Current Owners: 1964		in this cost report may be punishable by fine and/or imprisonment. Officer or (Date)
		RNMENTAL tate	Administrator of Provider (Title) Senior Vice President Finance
	IRS Exemption Code Corporation O xx "Sub-S" Corp.	County Other	(Signed) (Date) Paid (Print Name
	Limited Liability Co. Trust Other		Preparer and Title) (Firm Name & Address)
	In the event there are further questions about this report, please contact: Name: CRAIG L. ATER Telephone Number:		(Telephone) (309)823-7135 Fax # () MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numb	er Heritage Mai	or-Streator				# 0038331 Report Period Beginning: 1/01/2002 Ending: 12/31/2002
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/c	certification level(s) of	care; enter number	r of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	oeds			
						_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							NONE
	Beds at				Licensed		
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
	Report Period	Level of	Care	Report Period	Report Period		
	•			•	•		G. Do pages 3 & 4 include expenses for services or
1	110	Skilled (SNI	(7)	110	40,150	1	investments not directly related to patient care?
2			atric (SNF/PED)	-	.,	2	YES NO XX
3	0	Intermediat		0	0	3	
4		Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	0	Sheltered Ca	are (SC)	0	0	5	YES NO XX
6		ICF/DD 16	or Less			6	
							I. On what date did you start providing long term care at this location?
7	110	TOTALS		110	40,150	7	Date started 1964
	D. C F	41	·a				J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	the entire report per					YES Date 1964 NO xx
	1	2	3	4	5		77 777 d. 6 100 d. 16 16 36 10 d. d. d. d.
	Level of Care	Patient Days Public Aid	by Level of Care an	d Primary Source of	Payment	-	K. Was the facility certified for Medicare during the reporting year? YES NO xx If YES, enter number
			Deimata Dan	Other	Total		
8	SNF	Recipient 26,395	Private Pay 9,837	2,208	38,440	8	of beds certified and days of care provided 2,208
9	SNF/PED	40,395	9,037	2,208	30,440	9	Medicare Intermediary
_	ICF			V		10	Medicare intermediary
_	ICF/DD					11	IV. ACCOUNTING BASIS
	SC	0	0	0		12	MODIFIED
	DD 16 OR LESS	· ·	-			13	ACCRUAL XX CASH* CASH*
						+	
14	TOTALS	26,395	9,837	2,208	38,440	14	Is your fiscal year identical to your tax year? YES XX NO
	C. Damassid O.	our on our (Column 5	tina 14 dinidad bir 4-	tal liaanaad			Tax Year: Fiscal Year:
		cupancy. (Column 5, 1 line 7, column 4.)	95,74%	otai iicensed			* All facilities other than governmental must report on the accrual basis.
	bea days of	, commi 4.)	25.7.170	_			Memore valet than governmental mast report on the accrual busis.

STATE OF ILLI	NOIS				Page 3
#	0029221	Donaut Davied Deginnings	1/01/2002	Ending	12/21/2002

		Heritage Mano			#	0038331	Report Period	Beginning:	1/01/2002	Ending:	12/31/2002	_
	V. COST CENTER EXPENSES (through				llar)	ъ.	15 1 +0 1			EOD OHE	HOE ONLY	
	0 4 5		Costs Per Genera			Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total		4.0	
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	238,182	22,593		260,775		260,775	3,769	264,544			1
2	Food Purchase		169,806		169,806		169,806	(857)	168,949			2
3	Housekeeping	95,523	24,155		119,678		119,678		119,678			3
4	Laundry	45,672	16,869		62,541		62,541		62,541			4
5	Heat and Other Utilities			65,086	65,086		65,086	1,173	66,259			5
6	Maintenance	73,338	24,984	20,218	118,540		118,540	10,142	128,682			6
7	Other (specify):*											7
8	TOTAL General Services	452,715	258,407	85,304	796,426		796,426	14,227	810,653			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,382,304	122,812	5,536	1,510,652		1,510,652		1,510,652			10
10a	Therapy		236,268	43,336	279,604	(391,337)	(111,733)	183,050	71,317			10a
11	Activities	71,091	2,709		73,800		73,800		73,800			11
12	Social Services	21,670	103	4,655	26,428		26,428		26,428			12
13	Nurse Aide Training	7,965	582		8,547		8,547	2,095	10,642			13
14	Program Transportation	ŕ			,		,	,				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,483,030	362,474	53,527	1,899,031	(391,337)	1,507,694	185,145	1,692,839			16
	C. General Administration											
17	Administrative	67,969			67,969		67,969	97,405	165,374			17
18	Directors Fees							5,170	5,170			18
19	Professional Services			264,252	264,252		264,252	(254,519)	9,733			19
20	Dues, Fees, Subscriptions & Promotions			76,474	76,474	(60,225)	16,249	(2,370)	13,879			20
21	Clerical & General Office Expenses	132,061	7,776	17,231	157,068		157,068	204,881	361,949			21
22	Employee Benefits & Payroll Taxes			353,338	353,338		353,338	26,791	380,129			22
23	Inservice Training & Education			1,158	1,158		1,158	841	1,999			23
24	Travel and Seminar			7,435	7,435		7,435	(5,436)	1,999			24
25	Other Admin. Staff Transportation			· ·	· ·			` '				25
26	Insurance-Prop.Liab.Malpractice			41,555	41,555		41,555	1,973	43,528			26
27	Other (specify):*			7,720	7,720		7,720	(7,651)	69			27
28	TOTAL General Administration	200,030	7,776	769,163	976,969	(60,225)	916,744	67,085	983,829			28
26	TOTAL Operating Expense	2 125 555	(20, (55	007.004	2 (52 42)	(451.553)	2 220 054	266.455	2 495 221			26
29	(sum of lines 8, 16 & 28) *Attach a schedule if more than one type	2,135,775	628,657	907,994	3,672,426	(451,562)	3,220,864	266,457	3,487,321			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

#0038331

V. COST CENTER EXPENSES (continued)

Facility Name & ID Number

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHE	F USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			99,479	99,479		99,479	12,877	112,356			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,996	65,996		65,996	141	66,137			32
33	Real Estate Taxes			46,195	46,195		46,195		46,195			33
34	Rent-Facility & Grounds							7,392	7,392			34
35	Rent-Equipment & Vehicles			7,407	7,407		7,407	11,408	18,815			35
36	Other (specify):*											36
37	TOTAL Ownership			219,077	219,077		219,077	31,818	250,895			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					391,337	391,337		391,337			39
40	Barber and Beauty Shops		624	6,840	7,464		7,464		7,464			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,225	60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		624	6,840	7,464	451,562	459,026		459,026			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,135,775	629,281	1,133,911	3,898,967		3,898,967	298,275	4,197,242			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor-Streator

0038331

Report Period Beginning:

1/01/2002

Ending:

Page 5 12/31/2002

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	III Column	2 below, reference the	2	3	iai co:
		1	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,213)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,252	30		9
10	Interest and Other Investment Income	(100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(857)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(567)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,983)	24		19
20	Contributions	(1,651)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(5,812)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,954))	\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	325,229		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 325,229		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 298,275		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 1 2

(Se	e instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)		•	\$		47

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Heritage Manor-Streator

| ID# | 0038331 | Report Period Beginning: | 1/01/2002 | Ending: | 12/31/2002

Sch. V Line

	NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$	0	0	1
2			0	0	2
3			0	0	3
4			0	0	4
5			(3,213)	35	5
6			0	34	6
7			0		7
8			0		8
9			3,252	30	9
10				32	10
11			0		11
12			0		12
13			(857)	2	13
14			0	32	14
15			0	33	15
16		_	0	24	16
17		_	(567)	20	17
18		_	0	20	18
19			Ü	24	19
20			(1,651)	27	20
21			0	27	21
22			(23)	19	22
23			0	19	23
24		_	(6,000)	27	24
25			(5,812)	20	25
26			0	0	26
27			0	0	27
28			0	0	28
29			0	0	29
30			0	0	30
31			0	0	31
_			U	U	
32					32
33			0	33	33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49	Total		(14,871)		49

Summary A Facility Name & ID Number Heritage Manor-Streator SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61 # 0038331 Report Period Beginning: 1/01/2002 12/31/2002 **Ending:**

	SUMMARY OF PAGES 5, 5A, 6, 6A	1, 6B, 6C, 6D, 0	6E, 6F, 6G, 6F	AND 61									
													SUMMARY
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col.7)
1	Dietary	0	0	3,769	0	0	0	0	0	0	0	0	3,769 1
2	Food Purchase	(857)	0	0	0	0	0	0	0	0	0	0	(857) 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	1,173	0	0	0	0	0	0	0	0	1,173 5
6	Maintenance	0	0	10,142	0	0	0	0	0	0	0	0	10,142 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	(857)	0	15,084	0	0	0	0	0	0	0	0	14,227 8
	B. Health Care and Programs												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	183,050	0	0	0	0	0	0	0	0	0	183,050 10
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	2,095	0	0	0	0	0	0	0	0	2,095 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Programs	0	183,050	2,095	0	0	0	0	0	0	0	0	185,145 16
	C. General Administration												
17	Administrative	0	0	97,405	0	0	0	0	0	0	0	0	97,405 17
18	Directors Fees	0	0	5,170	0	0	0	0	0	0	0	0	5,170 18
19	Professional Services	(23)	(264,229)	9,733	0	0	0	0	0	0	0	0	(254,519) 19
20	Fees, Subscriptions & Promotions	(6,379)	0	4,009	0	0	0	0	0	0	0	0	(2,370) 20
21	Clerical & General Office Expenses	0	0	204,881	0	0	0	0	0	0	0	0	204,881 21
22	Employee Benefits & Payroll Taxes	0	0	26,791	0	0	0	0	0	0	0	0	26,791 22
23	Inservice Training & Education	0	0	841	0	0	0	0	0	0	0	0	841 23
24	Travel and Seminar	(11,983)	0	6,547	0	0	0	0	0	0	0	0	(5,436) 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	1,973	0	0	0	0	0	0	0	0	1,973 26
27	Other (specify):*	(7,651)	0	0	0	0	0	0	0	0	0	0	(7,651) 27
28	TOTAL General Administration	(26,036)	(264,229)	357,350	0	0	0	0	0	0	0	0	67,085 28
	TOTAL Operating Expense												
29	(sum of lines 8,16 & 28)	(26,893)	(81,179)	374,529	0	0	0	0	0	0	0	0	266,457 29

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Streator # 0038331 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col	1.7)
30	Depreciation	3,252	0	0	9,625	0	0	0	0	0	0	0	12,877	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(100)	0	0	241	0	0	0	0	0	0	0	141	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	7,392	0	0	0	0	0	0	0	7,392	34
35	Rent-Equipment & Vehicles	(3,213)	0	0	14,621	0	0	0	0	0	0	0	11,408	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(61)	0	0	31,879	0	0	0	0	0	0	0	31,818	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST			_										
45	(sum of lines 29, 37 & 44)	(26,954)	(81,179)	374,529	31,879	0	0	0	0	0	0	0	298,275	45

0038331

1/01/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Litter below the number of ALL o								
1		2			3			
OWNERS		RELATED NURSING HOMI		OTHER RELATED BUSINESS ENTITIES				
Name	Ownership %	Name	City		ie	City		Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

 $If yes, costs incurred \ as \ a \ result \ of \ transactions \ with \ related \ organizations \ must \ be \ fully \ itemized \ in \ accordance \ with$

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organiza	tion 58,436	GreenTree Therapy	100.00%	49,407	(9,029)	2
3	V								3
4	V	19	Adjustment for Related Organiza	tion 264,229	Heritage Enterprises, Inc.	100.00%		(264,229)	4
- 5	V								5
6	V	10a	Adjustment for Related Organiza	tion 203,537	GreenTree Pharmacy	100.00%	395,616	192,079	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			s 526,202			\$ 445,023	\$ * (81,179)	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS										Page 6A		
Facility Name & ID Number	Heritage Manor-Streator				#	0038331	1	Report Period Beginning:	1/01/2002	Ending:	12/31/2002	
VII. RELATED PARTIES (continued)												
B. Are any costs included in this	B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent,											
management fees, purchase o		YES		NO								

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2 3 Cost Per General Ledger 4			5 Cost to Related Organization	6	7	8 Difference:	
	1		5 Cost 1 et General Leuger	7	5 Cost to Related Of gamization		O		
~ -			_			Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
							Organization	Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 3,769	\$ 3,769	
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				0		17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,173	1,173	19
20	V	6	Maintenance				10,142	10,142	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				2,095	2,095	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				97,405	97,405	29
30	V	18	Directors Fees				5,170	5,170	30
31	V	19	Professional Services				9,733	9,733	31
32	V	20	Fees, Subscription, Promotions				4,009	4,009	32
33	V	21	Clerical & General Office Expenses				204,881	204,881	33
34	V	22	Employee Benefits & Payroll Taxes				26,791	26,791	
35	V	23	Inservice Training & Education				841	841	35
36	V	24	Travel and Seminar				6,547	6,547	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,973	1,973	38
39	Total			\$			s 374,529	s * 374,529	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF IL	LINOIS			Page 6B	

Facility Name & ID Number	Heritage Manor-Streator	#	0038331	Report Period Beginning:	1/01/2002	Ending:	12/31/2002
VII. RELATED PARTIES (continu B. Are any costs included in this management fees, purchase o	report which are a result of transactions with related organizations	? This includes rent	,				

 $If yes, costs incurred \ as \ a \ result \ of \ transactions \ with \ related \ organizations \ must \ be \ fully \ itemized \ in \ accordance \ with$

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
Selic	uuic v	Line	rem	Amount	Ivanic of Related Organization			-	•
15	17	27	Other	6	Haritana Fatamaiana Inc	Ownership 100.00%	Organization 0	Costs (7 minus 4)	15
15 16	V	30	Depreciation Depreciation	3	Heritage Enterprises, Inc.	100.0076	9,625	9,625	
17	V	31	Amortization of Pre-Op & Org				9,023	3,023	17
18	V	32	Interest				241	241	
19	V	33	Real Estate Taxes				0	241	19
20	V	34	Rent-Facility & Grounds		-		7,392	7,392	
21	v	35	Rent-Equipment & Vehicles		-		14,621	14,621	21
22	V	36	Other				0	14,021	22
23	v	38	Medically Nec Transportation				0		23
24	v	39	Ancillary Service Centers				0		24
25	v	40	Barber and Beauty Shops				0		25
26	v	41	Coffee and Gift Shops				0		26
27	v	42	Other				0		27
28	V						•		28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			s			s 31,879	s * 31,879	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Heritage Manor-Streator # 0038331 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6	6	7		8			
						Average Hou	rs Per Work				1		
					Compensation	Week Devo	oted to this	Compensatio	n Included	Schedule V.	1		
					Received	Facility and % of Total		in Costs	in Costs for this		1		
				Ownership	From Other	Work Week		Reporting Period**		Work Week Reporting Period** Colu		Column	1
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference			
1	Bill Froelich	Chairman of Board	Management	26.00	397,396	5	100.00	Director/Salary	\$ 18,205	line 17/18, col	1		
2	Tom Jefferson	Asst Secretary/Treasu	Management	10.00	390,860	5	100.00	Director/Salary	17,907	line 17/18, col	2		
3	Craig Hart	Secretary/Treasurer	Management	20.00	343,058	10	100.00	Director/Salary	15,717	line 17/18, col	3		
4	Joe Warner	President	Management	2.50	370,366	40	100.00	Director/Salary	16,968	line 17/18, col	4		
5	Bob Dickson	Executive Vice Presid	Management	0.80	92,266	40	100.00	Salary	4,227	line 17, col 7	5		
6	Cheryl Lowney	Executive Vice Presid	Management	0.30	186,564	50	100.00	Director/Salary	8,547	line 17/18, col	6		
7	Steve Wannemacher	Executive Vice Presid	Management	0.30	175,068	50	100.00	Director/Salary	8,021	line 17/18, col	7		
8	Connie Hoselton	Sr Vice President	Management	0.17	140,191	40	100.00	Salary	6,423	line 17, col 7	8		
9	Craig Ater	Sr Vice President	Management	0.21	143,176	50	100.00	Salary	6,560	line 17, col 7	9		
10											10		
11											11		
12											12		
13								TOTAL	\$ 102,575		13		

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

Facility Name & ID Number Heritage Manor-Streator # 0038331 Report Period Beginning: 1/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO xx	City / State / Zip Code	
	Phone Number ()	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()	

	1	2	3	4	5		6	7	8	9	T -
	Schedule V	<u>-</u>	Unit of Allocation	•	Number of		Total Indirect	Amount of Salary		Ź	
	Line		(i.e.,Days, Direct Cost,		Subunits Being		Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among		Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			Beds	2,401	24	\$	82.266	\$ 82,266	110		1
2	2	•	Beds	2,401	24	-	0	0	110	0	2
3	3		Beds	2,401	24		0	0	110	0	3
4			Beds	2,401	24		0	0	110	0	4
5	5	Heat & Other Utilities	Beds	2,401	24		25,593	0	110	1,173	5
6	6	Maintenance	Beds	2,401	24		221,381	58,785	110	10,142	6
7	7	Other	Beds	2,401	24		0	0	110	0	7
8	9	Medical Director	Beds	2,401	24		0	0	110	0	8
9	10	Nursing & Medical Records	Beds	2,401	24		0	0	110	0	9
10	11	Activities	Beds	2,401	24		0	0	110	0	10
11			Beds	2,401	24		0	0	110	0	11
12			Beds	2,401	24		45,737	39,267	110	2,095	12
13	14	Program Transportation	Beds	2,401	24		0	0	110	0	13
14	15	Other	Beds	2,401	24		0	0	110	0	14
15	17		Beds	2,401	24		2,126,096	2,126,096	110	97,405	15
16	18	Directors Fees	Beds	2,401	24		112,849	0	110	5,170	16
17			Beds	2,401	24		212,454	0	110	9,733	17
18			Beds	2,401	24		87,500	0	110	4,009	18
19		Clerical & General Office Expense		2,401	24		4,472,002	4,183,145	110	204,881	19
20		Employee Benefits & Payroll Taxe	Beds	2,401	24		584,769	0	110	26,791	20
21		9	Beds	2,401	24		18,362	0	110	841	21
22	24		Beds	2,401	24		142,902	0	110	6,547	22
23		Other Admin. Staff Transportatio	Beds	2,401	24		0	0	110	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,401	24		43,070	0	110	1,973	24
25	TOTALS					\$	8,174,981	\$ 6,489,559		\$ 374,529	25

STATE OF ILLINOIS	Page 8A

Facility Name & ID Number Heritage Manor-Streator	#	0038331	Report Period Beginning:	1/01/2002	Ending:	2/31/2002	
VIII. ALLOCATION OF INDIRECT COSTS							
			Name of Related	Organization			
A. Are there any costs included in this report which were derived from allocations of centr	al offi	ce	Street Address				
or parent organization costs? (See instructions.) YES NO			City / State / Zip	Code			
			Phone Number		()	_	
B. Show the allocation of costs below. If necessary, please attach worksheets.			Fax Number		()		

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	27	Other	Beds	2,401	24	\$	\$	110	\$	1
2	30	Depreciation	Beds	2,401	24	210,090		110	9,625	2
3	31	Amortization of Pre-Op & Org	Beds	2,401	24			110		3
4			Beds	2,401	24	5,270		110	241	4
5	33	Real Estate Taxes	Beds	2,401	24			110		5
6			Beds	2,401	24	161,349		110	7,392	6
7	35	Rent-Equipment & Vehicles	Beds	2,401	24	319,142		110	14,621	7
8			Beds	2,401	24			110		8
9	38	Medically Nec Transportation	Beds	2,401	24			110		9
10			Beds	2,401	24			110		10
11			Beds	2,401	24			110		11
12	41	Coffee and Gift Shops	Beds	2,401	24			110		12
13	42	Other	Beds	2,401	24			110		13
14										14
15										15
16										16
17										17
18										18
19		·			_					19
20		<u> </u>								20
21				<u> </u>						21
22		<u> </u>								22
23	·			•						23
24				•						24
25	TOTALS					\$ 695,851	\$		\$ 31,879	25

		STATE OF ILLINOIS	Page 9
Facility Name & ID Number	Heritage Manor-Streator	# 0038331 Report Period Beginnin	ng: 1/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10		
											Reporting	;	
					Monthly				Maturity	Interest	Period		
	Name of Lender	Relate	d**	Purpose of Loan	Payment	Date of	Amou	int of Note	Date	Rate	Interest		
		YES	NO		Required	Note	Original	Balance		(4 Digits)	Expense		
	A. Directly Facility Related												
	Long-Term												
1	LsSalle National Bank		XX	Mortgage	4640 plus Int	01/15/99	\$ 2,433,749	\$ 1,035,439	01/15/06	variable	\$ 42,28	32 1	
2	LsSalle National Bank		XX	Mortgage							4,84	14 2	
3												3	
4												4	
5												5	
	Working Capital												
6	Central Office Allocation		XX	Working Capital							18,8	70 6	T
7	Central Office Allocation		XX	Working Capital							24	11 7	
8												8	
													T
9	TOTAL Facility Related						\$ 2,433,749	\$ 1,035,439			\$ 66,2	37 9	
	B. Non-Facility Related*												
10	Interest Income										(1)	10)
11												11	ı.
12												12	1
13												13	j
14	TOTAL Non-Facility Related						\$	\$			\$ (10	00) 14	į
15	TOTALS (line 9+line14)						\$ 2,433,749	\$ 1,035,439			\$ 66,13	37 15	í

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$ Line #	

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0038331 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

Facility Name & ID Number Heritage Manor-Streator

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

B. Real Estate Taxes									
Real Estate Tax accrual used on 2001 report.	<i>Important</i> , please see the next worksheet, "I bill must accompany the cost report.	RE_Tax". The real	estate tax statement and	•	47,793	1			
1. Real Estate Tax accidal used oil 2001 lepoit.	am made addentificanty and odde reports			3	41,193	1			
2. Real Estate Taxes paid during the year: (Indicate the	ax year to which this payment applies. If payment covers	more than one year, de	tail below.)	s	45,847	2			
3. Under or (over) accrual (line 2 minus line 1).				s	(1,946)	3			
4. Real Estate Tax accrual used for 2002 report. (Detail	and explain your calculation of this accrual on the lines b	pelow.)		s	48,141	4			
	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)								
6. Subtract a refund of real estate taxes. You must offse classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For	s		6						
7. Real Estate Tax expense reported on Schedule V, line	33. This should be a combination of lines 3 thru 6.			\$	46,195	7			
Real Estate Tax History:									
Real Estate Tax Bill for Calendar Year: 1997	8		FOR OHF USE ONLY			T			
1998 1999	9 10	13	FROM R. E. TAX STATEMENT FOI	R 2001 \$		13			
2000 2001	11 12	14	PLUS APPEAL COST FROM LINE	5 \$		14			
		15	LESS REFUND FROM LINE 6	\$		15			
		16	AMOUNT TO USE FOR RATE CAL	.CULATION \$		16			

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME Heritage Mar	or-Streator	COUNTY La	Salle
FAC	ILITY IDPH LICENSE NUMBE	R 0038331		
CON	TACT PERSON REGARDING	THIS REPORT Craig Ater		
TEL	EPHONE (309)823-7135	FAX #: ()	_
A.	Summary of Real Estate Tax C	Cost		
	cost that applies to the operation home property which is vacant, i	real estate tax assessed for 2001 on the line of the nursing home in Column D. Real e rented to other organizations, or used for p clude cost for any period other than calend	estate tax applicable to any surposes other than long ter	portion of the nursing
	(A)	(B)	(C)	(D) Tax
				Applicable to
	Tax Index Number	Property Description	Total Tax	Nursing Home
1.	3431112000	Nursing Home	\$ 44,111.00	\$ 44,111.00
2.	3431129000	Nursing Home	\$ 1,737.00	\$ 1,737.00
3.		. <u> </u>	\$	\$
4.			\$	\$
5.		. <u> </u>	\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 45,848.00	\$ 45,848.00
B.	Real Estate Tax Cost Allocatio	ns		
	Does any portion of the tax bill a used for nursing home services?	apply to more than one nursing home, vaca YES NO		nich is not directly
		a schedule which shows the calculation of t must be allocated to the nursing home ba		

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which

C. Tax Bills

is normally paid during 2002.

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STATE OF ILLIN	DIC

17,000

Page 11

Facility Name & ID Number Heritage Manor-Streator # 0038331 Report Period Beginning: 1/01/2002 Ending: 12/31/2002 X. BUILDING AND GENERAL INFORMATION: 33,800 **B.** General Construction Type: Brick/Wood **Number of Stories** Square Feet: Exterior (c) Rent from Completely Unrelated Does the Operating Entity? xx (a) Own the Facility (b) Rent from a Related Organization. Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) xx (a) Own the Equipment (c) Rent equipment from Completely Does the Operating Entity? (b) Rent equipment from a Related Organization. Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). YES NO Does this cost report reflect any organization or pre-operating costs which are being amortized? XX If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 2 3 Square Feet Year Acquired A. Land. Use Cost Land 17,000

3 TOTALS

0038331

Report Period Beginning:

Page 12 1/01/2002 Ending: 12/31/2002

Facility Name & ID Number Heritage Manor-Streator # 0038
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ng Depreciation-Including Fixed Equ	2	3		test dollar.	6	7	8	9	$\overline{}$
	•	FOR OHF USE ONLY	Year	Year	·	Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	110				\$ 348,848	\$		\$	\$	\$	4
5					440,122					-	5
6					110,222						6
7											7
8											8
	Impro	ovement Type**									_
9	1980 Improve			1980	12,172						9
	1981 Improve			1981	13,748						10
11	1982 Improve	ements		1982	18,366						11
	1983 Improve			1983	9,250						12
	1984 Improve			1984	1,329						13
	1985 Improve			1985	4,100						14
	1986 Improve			1986	57,336						15
	1987 Improve			1987	6,225						16
	1988 Improve			1988	48,818						17
	1989 Improve			1989	22,687						18
	1990 Improve			1990	31,584						19
	1991 Improve			1991	3,560						20
	1992 Improve			1992	19,172						21
22	1993 Improve	ements		1993	23,135						22
23	1994 Improve	ements		1994	22,036						23
	1995 Improve	DENSING UNIT		1995	39,228						24
26	YORK CONI	DENSING UNIT		1996	3,910						25
27											26 27
28											28
29						 		 	ļ		29
30											30
31									1		31
32									1		32
33											33
	C/O Allocatio	n						9,625	9,625		34
	Book Depreci					55,935		59,586	3,651	1,026,115	35
36						, -		,	<u> </u>	, , , -	36

See Page 12A, Line 70 for total

*Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

0038331

Report Period Beginning:

Page 12A

1/01/2002 Ending:

12/31/2002

Facility Name & ID Number Heritage Manor-Streator
XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year **Current Book** Life Straight Line Accumulated Constructed Cost Depreciation Depreciation Depreciation Improvement Type** in Years Adjustments 37 Interior Rehab---Facility 1997 286,974 37 38 Roof 1997 5,232 38 9,530 39 Sprinkler System 1997 39 40 Code Alert 1997 1,879 40 41 41 42 Code Alert 2,000 656 42 43 Bathroom Door 43 1998 44 Interior Rehab 1998 11,815 44 45 45 46 Door Alarms 1999 3,675 46 47 47 48 Water Heater 4,114 48 49 Exhaust Fans 49 2000 931 50 Booster Heater -- Water Heater 1,465 50 51 52 53 52 Professional Fees---Building Renovation 2001 27,964 53 Sprinkler Replacement 2001 4,955 54 AC Unit with Installation 2001 4,372 54 55 55 Exterior Painting 2001 6,545 56 Code Alert System 2001 4,592 56 57 58 Roof 58 48,840 2002 2002 59 Sewer line 20,615 59 1,213 60 60 Condensing Unit 61 62 62 63 63 64 64 65 66 66 67 67 68 69 70 TOTAL (lines 4 thru 69) 1,572,993 55,935 69,211 13,276 1,026,115 70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B 12/31/2002 Facility Name & ID Number Heritage Manor-Streator # 0038
XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0038331 Report Period Beginning: 1/01/2002 Ending:

l See inst	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 1,572,993	\$ 55,935		\$ 69,211	s 13,276	\$ 1,026,115	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18 19
20								20
21								21
22								22
23							-	23
24							 	24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,572,993	\$ 55,935		\$ 69,211	s 13,276	\$ 1,026,115	34

 $^{{\}rm **Improvement\ type\ must\ be\ detailed\ in\ order\ for\ the\ cost\ report\ to\ be\ considered\ complete}.$

CIT	7 A F	$\Gamma \mathbf{F}$	ΔT	TI	-	TAT	α	C

Page 13 Facility Name & ID Number 0038331 **Report Period Beginning:** 1/01/2002 12/31/2002 Heritage Manor-Streator **Ending:**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	l 1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 663,816	\$ 43,544	\$ 43,145	\$ (399)		\$ 570,953	71
72	Current Year Purchases	29,488						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 693,304	\$ 43,544	\$ 43,145	\$ (399)		\$ 570,953	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	L. Summary of Care-Related Assets	I	L		
			Reference	Amount		1
	81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,283,297	81	
	82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,479	82	
Ī	83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 112,356	83	**
Γ	84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,877	84	
Π	85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,597,068	85	1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

									STAT	TE OF ILLINOIS	3						Page 14
Faci	lity Name & I	D Number	Н	Ieritage Man	or-Strea	itor			#	0038331		Report P	eriod B	eginning:	1/01/2002	Ending:	12/31/2002
XII.	2. Does the	and Fixed Equ Party Holding	g Lease ay real	:	,	on to rent	al amount	shown below o		column 4? YES]NO						
		1		2		3		4		5		5					
		Year		Numbe	-	Date of		Rental		Total Years		Years					
	0	Construct	ed	of Beds	i	Lease		Amount		of Lease	Renewal	Option*		40 1700 4	1		
2	Original Building:						e						3		dates of curren		ment:
3	Additions						3					_	4	Ending			
5	Additions											_	5	Litting			
6										_		_	6	11. Rent to be	e paid in future	years under	the current
7	TOTAL						\$			·			7	rental agr	eement:		
	This amo	rately any am unt was calcu ngth of the lea	lated b							*				Fiscal Year 12. 13. 14.	/2003 /2004 /2005	Annual R S S S	ent
		ble equipmen Amount for m	t renta ovable	l included in equipment:	building	g rental?	. (See instr	uctions.) Description:		, computer equip		the breakd	own of	movable equipme	ent)		
	1	entai (See insi	ir uctioi	2	1		3			4		7					
	-			Model Year			Monthly 1	Lease		Rental Expense	,						
	Use			and Make			Payme	ent		for this Period		_			is an option to		
17			-			\$			\$		17				rovide comple	te details on a	ttached
18 19											18 19			schedule	е.		
20					ĺ						20			** This am	ount plus any	amortization (of lease
21	TOTAL					\$			\$		21	7		expense	must agree wi	th page 4, line	34.

				S	TATE OF ILLI	NOIS					Page 15
		ritage Manor-Streator				#	0038331	Report Period Beginning:	1/01/2002	Ending:	12/31/2002
XIII. EXP	PENSES RELATING TO NURSE	AIDE TRAINING PROGRAMS	(See ins	structions.)							
A. T	YPE OF TRAINING PROGRAM	(If aides are trained in another	facility p	orogram, attach a s	chedule listing t	he facility	name, addres	s and cost per aide trained in t	hat facility.)		
	1. HAVE YOU TRAINED AID! DURING THIS REPORT	ES YES	2.	CLASSROOM	PORTION:			3. <u>CLINICAL PO</u>	ORTION:	_	
	PERIOD?	NO		IN-HOUSE PRO	OGRAM			IN-HOUSE PR	ROGRAM		
	If "yes", please complete the	remainder		IN OTHER FAC	CILITY			IN OTHER FA	CILITY		
	of this schedule. If "no", provexplanation as to why this tra	ride an		COMMUNITY	COLLEGE			HOURS PER	AIDE		
	not necessary.	ming was		HOURS PER A	IDE						
В. Е	XPENSES	ALL	OCATIO	ON OF COSTS	(d)			C. CONTRACTUAL I	NCOME		
		1	l	2	3		4	In the box belo facility receive			
			Fac	cility						_	
		Drop	-outs	Completed	Contract		Total	\$	·		
	Community College Tuition	\$		\$	\$	\$					
2	Books and Supplies			582	l		582	D. NUMBER OF AIDE	STRAINED		

7,965

8,547

8,547

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(a)

(b)

(c)

(e)

3 Classroom Wages

5 In-House Trainer Wages

SUM OF line 9, col. 1 and 2

4 Clinical Wages

6 Transportation Contractual Payments Nurse Aide Competency Tests

TOTALS

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

7,965

8,547

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Page 16 12/31/2002 Facility Name & ID Number Heritage Manor-Streator # 0038331 Report Period Beginning: 1/01/2002 Ending:

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	()	1	2	3	4	5	6	7	8	
		Schedule V	Staf	Î	Outsid	le Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other t	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 16,712	\$:	\$ 16,712	1
	Licensed Speech and Language									
2	Development Therapist	10a/3	hrs			21,550			21,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			(6,481)	39,536		33,055	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39/3	prescrpts				388,811		388,811	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				2,526			2,526	13
14	TOTAL			\$		\$ 34,307	\$ 428,347		\$ 462,654	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached. As of 12/31/2002 (last day of reporting year)

		1		2 After	
		C	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	18,103	\$	1
2	Cash-Patient Deposits		8,272		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance		464,370		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance		28,407		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)		4,877,092		8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	5,396,244	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		50,000		13
14	Buildings, at Historical Cost		1,445,280		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		668,098		16
17	Accumulated Depreciation (book methods)		(1,047,721)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): Deferred Tax Asset		14,936		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	1,130,593	\$	24
					
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	6,526,837	\$	25

		1 O	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	78,207	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		8,272		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		240,596		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		2,695		31
32	Accrued Real Estate Taxes(Sch.IX-B)		48,141		32
33	Accrued Interest Payable		3,046		33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Security Deposits		15,180		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	396,137	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable		1,035,439		40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	1,035,439	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	1,431,576	\$	46
	,				
47	TOTAL EQUITY(page 18, line 24)	\$	5,095,261	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	6,526,837	\$	48

^{*(}See instructions.)

			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	4,686,472	1
2	Restatements (describe):		, ,	2
3	Audit Adjustment		12,999	3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	4,699,471	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		395,790	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	395,790	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	5,095,261	24

^{*} This must agree with page 17, line 47.

Ending:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 4,343,989	1
2	Discounts and Allowances for all Levels	(535,193)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,808,796	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	126,014	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 126,014	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	9,273	11
12	Gift and Coffee Shop	862	12
13	Barber and Beauty Care	10,944	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	350,010	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,444	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 372,533	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	100	25
26		\$ 100	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		·	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,307,443	30

		2		
	Expenses	Amou	ınt	
	A. Operating Expenses			
31	General Services	790	5,426	31
32	Health Care	1,899	0,031	32
33	General Administration	970	5,969	33
	B. Capital Expense			
34	Ownership	219	0,077	34
	C. Ancillary Expense			
35	Special Cost Centers		7,464	35
36	Provider Participation Fee			36
	D. Other Expenses (specify):			
37	Loss from Non-Nursing property	12	2,686	37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,911	1,653	40
41	Income before Income Taxes (line 30 minus line 40)**	395	5,790	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 395	5,790	43

*	This must	t agree with	page 4,	line 45,	column 4.
---	-----------	--------------	---------	----------	-----------

*	Does this agree wit	th taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Streator

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	(This schedule must cover the	1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,579	1,969	\$ 42,220	\$ 21.44	1
2	Assistant Director of Nursing	2,240	2,288	51,485	22.50	2
3	Registered Nurses	8,463	9,592	188,731	19.68	3
4	Licensed Practical Nurses	14,145	15,493	269,875	17.42	4
5	Nurse Aides & Orderlies	70,952	76,900	768,827	10.00	5
6	Nurse Aide Trainees	1,219	1,219	7,965	6.53	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,818	5,242	61,166	11.67	8
9	Activity Director					9
10	Activity Assistants	7,886	8,583	71,091	8.28	10
11	Social Service Workers	1,874	2,060	21,670	10.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,608	22,607	238,182	10.54	15
16	Dishwashers					16
17	Maintenance Workers	6,019	6,651	73,338	11.03	17
	Housekeepers	11,375	12,379	95,523	7.72	18
19	Laundry	5,505	6,156	45,672	7.42	19
20	Administrator	2,080	2,080	67,969	32.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,603	9,747	132,061	13.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,366	182,966	\$ 2,135,775 *	\$ 11.67	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		0		36
37	Medical Records Consultant		300		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,156		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,655		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,111		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		\$		53

^{**} See instructions.

STATE	OF	ILLINOIS	
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0038331 1/01/2002 Facility Name & ID Number Heritage Manor-Streator **Report Period Beginning:** Ending: 12/31/2002 XIX. SUPPORT SCHEDULES A. Administrative Salaries Ownership D. Employee Benefits and Payroll Taxes F. Dues, Fees, Subscriptions and Promotions Description Description Name Function % Amount Amount Amount IDPH License Fee Jeanett Strobla Administrator 67,969 Workers' Compensation Insurance 24,902 400 **Unemployment Compensation Insurance** 18,763 Advertising: Employee Recruitment 876 FICA Taxes 163,387 Health Care Worker Background Check **Employee Health Insurance** 114,067 (Indicate # of checks performed 231 Employee Meals Central Office Allocation 4,009 Illinois Municipal Retirement Fund (IMRF)* Promotional Advertising 4,763 Public Relations 1,049 **Employee Hepatitis Vaccine** 1,791 TOTAL (agree to Schedule V, line 17, col. 1) Employee Benefits -30,428 Dues and Subscriptions 8,339 (List each licensed administrator separately.) **Employee Benefits - central office** 26,791 License and Fees 67,969 591 B. Administrative - Other Less: Public Relations Expense (1,049)Description Non-allowable advertising (567) Amount Yellow page advertising (4,763) TOTAL (agree to Schedule V, 380,129 TOTAL (agree to Sch. V, 13,879 line 22, col.8) line 20, col. 8) TOTAL (agree to Schedule V, line 17, col. 3) E. Schedule of Non-Cash Compensation Paid G. Schedule of Travel and Seminar** (Attach a copy of any management service agreement) to Owners or Employees C. Professional Services Description Amount Vendor/Pavee Type Amount Description Line# Amount **Heritage Enterprises Management Fees** 264,229 **Out-of-State Travel** Clifton Gunderson Accounting 0 0 In-State Travel 4,228 46 Seminar Expense 3,161 Non Allowable (11,983)0 Central Office Allocation 6,547 Legal Fees (Adjusted to zero) 23 0 **Entertainment Expense** TOTAL (agree to Schedule V, line 19, column 3) TOTAL (agree to Sch. V,

264,252

(If total legal fees exceed \$2500 attach copy of invoices.)

line 24, col. 8)

1,999

TOTAL

Page 21

^{*} Attach copy of IMRF notifications

^{**}See instructions.

Page 22 12/31/2002 Report Period Beginning: 1/01/2002 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

	(See instructions.)				`		,	,					
	1	2	3	4	5	6	7	8	9	10	11	12	13
	I	Month & Year	Total Cost	Useful		Т	T	Amount of	Expense Amor	tized Per Year	T	1	
	Improvement Type	Improvement Was Made	Total Cost	Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		s		l _s	S	S	S	s	S	S	s	s

Facilit	S y Name & ID Number Heritage Manor-Streator	STATE (#	OF ILLINOIS 0038331	Report Period Beginning:	1/01/2002	Ending:	Page 23 12/31/2002
	ENERAL INFORMATION:			1 0			-
		(13)		supplies and services which are of the Public Aid, in addition to the daily in			
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Illinois Healthcare Association		•	ection of Schedule V? yes			
(3)	Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? yes	(14)	the patient census is a portion of the	building used for any function other listed on page 2, Section B? no building used for rental, a pharmacy explains how all related costs were a	, day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?		Indicate the cost o on Schedule V. related costs?		assified to employ meal income be the amount. \$	oeen offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? yes 7 years	(16)	Travel and Transp	ortation	no		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10		If YES, attach a	complete explanation. eparate contract with the Departmen	nt to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ all travel expense relates to transporting period age logs been maintained? yes			
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.		e. Are all vehicles times when not	stored at the nursing home during the in use? yes	•		
(9)	Are you presently operating under a sublease agreement? YES xx NO		out of the cost r	commuting or other personal use of eport? yes ity transport residents to and fi	· ·		
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO no If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.		Indicate the a	mount of income earned from p n during this reporting period.			<u>no</u>
		(17)	Firm Name:	performed by an independent certifi	•	The instruct	No tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 60,225 This amount is to be recorded on line 42 of Schedule V.		been attached?	that a copy of this audit be included No If no, please explain.			
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.		out of Schedule V				
		(19)	performed been at	re in excess of \$2500, have legal invalued to this cost report? yes d a summary of services for all arch		•	ices

Name of Street	Service.	GL G	map Salpylisa mping line 6 Co	Typ 1 Mak 6 pg 1 kdjun 14 – Line 6 – Annes	-	LOW PRITY CA. HAND. LOW ACCURAGE MAJOO LOW ALLOW FOR DOCUMENTMENT LOW ACCURATION ACC. LOW ACC.	
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100	RESIDENT FUNDS	6,273 14,496			100	LANGUAGES ADDRESS - LANGUAGES	
in	RESIDENCE PERCENSES DETENDINGNESS	408			200	DISTRIBUTION PAYABLE DISTRIBUTION DISTRIBUTION	
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